The Linacre Quarterly

Volume 53 | Number 2 Article 19

5-1-1986

Current Literature

Catholic Physicians' Guild

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Material appearing below is thought to be of particular interest to Linacre Quarterly *readers because of its moral, religious, or philosophic content. The medical literature constitutes the primary, but not the sole source of such material. In general, abstracts are intended to reflect the substance of the original article. Contributions and comments from readers are invited. (E.G. Laforet, M.D., 170 Middlesex Rd. Newton LowerFalls, MA 02167.*

Curran WJ: Defining appropriate medical care: providing nutrients and hydration for the dying. *New Eng J Med* **313:940-942 10 Oct 1985**

The New Jersey Supreme Court achieved national prominence in matters of medicolegal requirements of critically ill individuals with its decision in the Karen Ann Quinlan case, whereby the patient's guardian was permitted to decide about life-support issues. More recently the same court rendered a decision *(In the Matter of Claire Conroy)* permitting the removal of a nasogastric feeding tube under appropriate guidelines. Furthermore, the court ignored the ethics committee approach that had been favored in *Quinlan* and instead emphasized the state ombudsman program in these cases.

Steinbrook R, Lo B: The case of Elizabeth Bouvia: starvation, suicide, or problem patient? *Arch Int Med* 146:161-164 Jan 1986

With much media and legal attention a 26-year old women with cerebral palsy entered a hospital with the announced intention of starving to death. Much controversy ensued and the attendant publicity obscured significant aspects of the case. For example while a competent patient may refuse care, he or she may not ask attendants to assist in suicide or in direct killing. Furthermore, providing nutrition should be considered a therapeutic intervention in itself and thus its indications, benefits and risks must be evaluated.

Annas GJ: Killing with kindness: why the FDA need not certify drugs for execution safe and effective. *Am J Public Health* **75:1096-1099 Sep 1985**

The use of lethal injection to administer the death penalty is becoming more common. In addition to questions about its being "more humane" and about direct physician involvement, the issue of requiring the Food and Drug Administration (FDA) to ensure that the drugs used are "safe and effective" has been raised by some opponents of the death penalty. A U.S. Supreme Court decision held correctly that the FDA was not required to establish such standards. "The real issue is whether the death penalty, no matter how kindly administered, has any place in a society that calls itself civilized."

Brewin TB: Truth, trust and paternalism. *Lancet* **pp. 490-492 31 Aug 1985**

The idea of imparting a plethora of information to every patient, under the rubric of "informed consent", can be carried to absurd lengths. Communication is crucial in medicine and its object is, in part, to encourage and protect the patient. Thus some compromise seems necessary between the extremes of "informed consent" and "paternalism". As in other areas of living, a certain component of trust is required to facilitate this compromise. "Who should make the compromise? Presumably it should be those members of society who have most experience of all the subtle and paradoxical ways in which human beings may react to illness and to

fear; and who have had the greatest opportunity of learning, from first hand experience, when to speak out and when to keep silent. In other words, doctors and nurses, rather than philosophers or experts in ethics."

Smith CT Jr: A search for easy answers in complex circumstances. *Hospital & Health Services Adm* **30:54-62 Sep/Oct 1985**

Progress in biomedical technology has produced an increase in ethical dilemmas, notably in the neonatal intensive care unit. The experience of that at Yale-New Haven Hospital is examined in the light of a "major media expose of its practice".

Steinbrook R, Lo B, Moulton J, Saika G, Hollander H, Volberding PA: Preferences of homosexual men with AIDS for life-sustaining treatment. *New Eng J Med* **314:457-460 13 Feb 1986**

In order to study preferences of homosexual men with AIDS for life-sustaining treatment, a survey of 118 patients was conducted by questionnaire. A wide majority (78%) had given consideration to the type of care they would want if they developed *Pneumocystis carinii* pneumonia, and almost as many (66%) had thought about naming a proxy medical decision-maker in the event of incompetence. The study further showed that, contrary to the conventional wisdom, patients with AIDS wish to engage in discussions with medical personnel about life-sustaining treatment and they do not experience negative emotional reactions as a result. In addition, without such discussions it is not possible to predict a patient's preference for care.

Skrabanek P: Preventive medicine and morality. *Lancet* **pp. 143-144 18 Jan 1986**

"Is longevity a worthwhile social objective?" In many ways this aim of modern "preventive medicine" intrudes on freedom unnecessarily; "its ideology is totalitarian, its ethics perverse." "The issues of preventive medicine have little to do with science, relative risks, and risk factors. They could be more profitably debated within the framework to which they belong — ethics, politics, and vested interests."

Stephens RL: 'Do not resuscitate' orders: ensuring the patient's participation. *JAMA* **255:240-241 10 Jan 1986**

Although "do not resuscitate" orders are becoming more common and often are administratively encouraged, it would seem that not all competent patients are afforded the opportunity to participate in this decision. This defect is not addressed by the "living will" because it fails to guarantee that the patient has been adequately educated about the medical data. In addition, the "living will" does not provide for a definite election for or against resuscitation. In an attempt to remedy these and other difficulties, an expanded form has been revised for use in appropriate clinical situations.

(See also: **Younger SJ** *et al.*: **'Do not resuscitate' orders: incidence and implications in a medical intensive care unit.** *JAMA* **253: 54-57 4 Jan 1985)**

McLaughlin JF, Shurtleff DB, Lamers JY, Stuntz JT, Hayden PW, Kropp RJ: Influence of prognosis on decisions regarding the care of newborns with myelodysplasia. *New Eng J Med* **312:1589-1594 20 June 1985**

Between 1965 and 1982 the same prognostic criteria were used to plan the care of 212 newborns with myelodysplasia. Technological progress and societal changes have tended to improve the outcome. Early surgical care is recommended for most newborns with this problem. Treatment selection should be made after informing the family about prognosis, complications, available treatments, and educational and social options.

Gross RH: Newborns with myelodysplasia — the rest of the story. (Editorial) *New Eng J Med* **312:1632-1634 20 Jun 1985**

Follow-up studies of newborns with myelodysplasia who have been treated have centered on physical factors alone, although self-esteem, independence, and mobility have been shown to be critical features when these patients reach young adulthood. Such features are dependent upon the care that the child receives *after* the neonatal period and constitute "the rest of the story" that must be addressed by all concerned.

Hentoff N: The awful privacy of Baby Doe. *Atlantic Monthly* **255:54-62 Jan 1985**

A parental decision to withhold treatment from a neonate with a treatable or manageable defect has generally been considered a private one. The right of the infant to due process and to equal protection under the law is ignored, also under the privacy rubric. Legislative remedies are in progress.

Radovsky SS: Bearing the news. *New Eng J Med* **313:586-588 29 Aug 1985**

Whether or not to convey unpleasant information to the patient continues to be debated, although there has been a gradual acceptance of the fact that it should be done. There are four reasons for imparting truthful information. First, it is not possible to determine in advance what patients should not be informed. Second, lying to a patient may destroy trust. Third, lying is wrong in an abstract sense. Fourth, failure to inform a patient may merely reflect the physician's personal discomfiture with the facts of life and death.

Summers JW: Closing unprofitable services: ethical issues and management responses. *Hospital & Health Services Adm* **30:8-28 Sep/Oct 1985**

The decision to close an unprofitable service in a hospital requires not only analysis, public relations, marketing and planning, but also consideration of ethics. "By integrating values analysis with more traditional management tasks, the challenges of service closure can be converted into opportunities to demonstrate how your institution has met or exceeded its ethical obligations."

Oglesby DK Jr: Ethics and hospital administration. *Hospital & Health Services Adm* **30:29-43 Sep/Oct 1985**

The modern healthcare environment poses ethical issues concerning, *inter alia*, allocation of resources, development of biomedical technology, and quantity versus quality of life. Ultimately the ethical decision in such matters rests with the individual administrator. "Therefore, our personal background and philosophy on ethics is critical in determining our final decisions."

Marsh FJ: Health care cost containment and the duty to treat. *J Legal Med* **6:157-190 1985**

The rapidly escalating cost of health care has mandated cost containment programs such as the DRGs. These will necessarily affect the professional autonomy of the physician and his duty to treat. He will be placed in the position of serving two masters, his hospital and his patient. Eventually a choice will be required, and this will affect not only the physician's duty to treat and the standard of patient care but even medicine itself as an institution.
